



RULE-MAKING ORDER

CR-103 (June 2004)
(Implements RCW 34.05.360)

Agency: Insurance Commissioner

☒ **Permanent Rule**
☐ **Emergency Rule**

Effective date of rule:

Permanent Rules

☒ 31 days after filing.
☐ Other (specify) _____ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Effective date of rule:

Emergency Rules

☐ Immediately upon filing.
☐ Later (specify) _____

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: These new regulations are necessary to assure compliance with the standards prescribed by the Medicare Modernization Act (MMA) and are consistent with the amendments to the NAIC Medicare Supplement Insurance Minimum Standards Model Act that were adopted as a result of the MMA. The Centers for Medicare & Medicaid Services (CMS) requires states to implement the updated NAIC model amendments by September 8, 2005.

Insurance Commissioner Matter No. R 2004-08

Citation of existing rules affected by this order:

Repealed: WAC 284-66-077
Amended: WAC 284-66-010 through WAC 284-66-400
Suspended:

Statutory authority for adoption: RCW 48.02.060 and 48.66.165

Other authority :

PERMANENT RULE ONLY (Including Expedited Rule Making)

Adopted under notice filed as WSR 05-13-182 on 6/22/05
Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: _____ phone () _____
Address: _____ fax () _____
e-mail _____

EMERGENCY RULE ONLY

Under RCW 34.05.350 the agency for good cause finds:

- ☐ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
- ☐ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

Date adopted:

August 4, 2005

NAME (TYPE OR PRINT)

Mike Kreidler

SIGNATURE

TITLE

Insurance Commissioner

CODE REVISER USE ONLY
Information input by Agency

CODE REVISER'S OFFICE
STATE OF WASHINGTON
FILED

AUG 4 2005

Time _____ **1:50** **PM**
WSR _____ **05-17-019** _____

(COMPLETE REVERSE SIDE)

**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	<u>13</u>	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in the agency's own initiative:

New	<u>1</u>	Amended	<u>21</u>	Repealed	<u>1</u>
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The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	_____	Repealed	_____

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-010 Purpose. The purpose of this chapter is to ~~((effectuate the provisions of RCW 48.20.450, 48.20.460 and 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, and to))~~ supplement the requirements of chapter 48.66 RCW, the Medicare Supplemental Health Insurance Act; to assure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare program; to provide for the reasonable simplification and standardization of the coverage, terms, and benefits of Medicare supplement insurance policies and certificates, and to eliminate policy provisions ~~((which))~~ that may duplicate Medicare benefits as the federal Medicare program changes; to facilitate public understanding and comparison of ~~((such))~~ policies and to eliminate provisions contained in ~~((such))~~ policies ~~((which))~~ that may be misleading or confusing; to establish minimum standards for Medicare supplement insurance, an "outline of coverage" and other disclosure requirements; to prohibit the use of certain provisions in Medicare supplemental insurance policies; to define and prohibit certain acts and practices as unfair methods of competition or unfair or deceptive acts or practices; and to establish loss ratio requirements, policy reserves, filing and reporting procedures.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-020 Applicability and scope. (1) Subject to subsection (2) of this section, except as provided by federal law, chapter 48.66 RCW, or as otherwise specifically provided by this chapter, this chapter (~~((shall apply))~~) applies to every group and individual policy of disability insurance and to every subscriber contract of an issuer (other than a policy issued (~~((pursuant to))~~) under a contract (~~((under))~~) provided for in section 1876 of the Social Security Act [42 U.S.C. section 1395 et seq.] or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss (g)(1)), (~~((which))~~) that relates its benefits to Medicare, or (~~((which))~~) is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. All such policies or contracts are referred to in this chapter as "Medicare supplemental insurance" or "Medicare supplement insurance policy" or "Medicare supplement coverage."

(2)(a) Medicare supplement insurance policies delivered (~~((prior to))~~) before January 1, 1989, (~~((which))~~) that are renewable solely at the option of the insured by the timely payment of premium (~~((shall be))~~) are subject to the provisions of this chapter except with respect to WAC 284-66-060, 284-66-200, 284-66-210, 284-66-310, and 284-66-350. To the extent that the provisions of this chapter do not apply to (~~((such))~~) these policies, chapter 284-55 WAC (~~((shall apply))~~) applies.

(b) Medicare supplement insurance policies delivered between January 1, 1989, and December 31, 1989, (~~((and which))~~) that are renewable solely at the option of the insured by the timely payment of premium (~~((shall be))~~) are governed by this chapter except with respect to the requirements of WAC 284-66-210 and 284-66-350.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-030 Definitions. For purposes of this chapter:
(1) "Applicant" means:

(a) In the case of an individual Medicare supplement insurance policy, the person who seeks to contract for insurance benefits; and

(b) In the case of a group Medicare supplement insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement insurance policy regardless of the situs of the group master policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Issuer" includes insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates.

(5) "Direct response issuer" means an issuer who, as to a particular transaction, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent.

(6) "Disability insurance" is insurance against bodily injury, disablement or death by accident, against disablement resulting from sickness, and every insurance ~~((appertaining thereto))~~ relating to disability insurance. For purposes of this chapter, disability insurance ~~((shall))~~ includes policies or contracts offered by any issuer.

(7) "Health care expense costs," for purposes of WAC 284-66-200(4), means expenses of a health maintenance organization or health care service contractor associated with the delivery of health care services ~~((which expenses))~~ that are analogous to incurred losses of insurers. ~~((Such expenses shall not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, and "claims" processing costs.))~~

(8) "Policy" includes agreements or contracts issued by any issuer.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(10) "Premium" means all sums charged, received, or deposited as consideration for a Medicare supplement insurance policy or the continuance thereof. An assessment or a membership, contract, survey, inspection, service, or other similar fee or charge made by the issuer in consideration for ~~((such))~~ the policy is deemed part of the premium. "Earned premium" ~~((shall))~~ means the "premium" applicable to an accounting period whether received before, during or after ~~((such))~~ that period.

(11) "Replacement" means any transaction ~~((in which))~~ where new Medicare supplement coverage is to be purchased, and it is

known or should be known to the proposing agent or other representative of the issuer, or to the proposing issuer if there is no agent, that by reason of (~~such~~) the transaction, existing Medicare supplement coverage has been or is to be lapsed, surrendered or otherwise terminated.

(12) "Secretary" means the Secretary of the United States Department of Health and Human Services.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-040 Policy definitions and terms. No policy or certificate may be advertised, solicited, issued for delivery in this state (~~after July 1, 1992,~~) as a Medicare supplement insurance policy or certificate unless (~~such~~) the policy or certificate contains definitions or terms (~~which~~) that conform to the requirements of this section.

(1) "Accident," "accidental injury," or "accidental means" (~~shall~~) must be defined to employ "result" language and (~~shall~~) may not include words (~~which~~) that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words or description or characterization.

(a) The definition (~~shall~~) may not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person (~~which~~) that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(b) (~~Such~~) The definition may provide that injuries (~~shall~~) do not include those injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(2) "Benefit period" or "Medicare benefit period" may not be defined more restrictively than as defined in the Medicare program.

(3) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" (~~shall~~) may not be defined more restrictively than as defined in the Medicare program.

(~~(3)~~) (4) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Health Care Organizations, but not more restrictively than as defined in the Medicare program.

~~((4))~~ (5) "Medicare" ~~((shall))~~ must be defined in the policy and certificate ~~((. Medicare may be defined))~~ as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended." ~~((or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.~~

~~(5))~~ (6) "Medicare eligible expenses" means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(7) "Physician" ~~((shall))~~ may not be defined more restrictively than as defined in the Medicare program.

~~((6))~~ (8) "Sickness" ~~((shall))~~ may not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person ~~((which))~~ that first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-050 Policy provisions. (1) No policy may be advertised, solicited, or issued for delivery in this state as a Medicare supplement insurance policy unless ~~((such policy))~~ it meets or exceeds the requirements ~~((for such policies))~~ imposed by chapter 48.66 RCW.

(2) ~~((No))~~ A Medicare supplement policy or certificate in force in this state ~~((shall))~~ may not contain benefits ~~((which))~~ that duplicate benefits provided by Medicare.

(3) Except for permitted preexisting condition clauses as described in WAC 284-66-063 (1)(a) no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if ~~((such))~~ the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(4) The terms "Medicare supplement," "Medicare wrap-around," "Medigap," or words of similar import ~~((shall))~~ may not be used to describe an insurance policy unless ~~((such))~~ the policy is issued in compliance with chapter 48.66 RCW and this chapter.

(5) Subject to WAC 284-66-063 (1)(c), a Medicare supplement policy with benefits for outpatient prescription drugs in existence before January 1, 2006, must be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(6) A Medicare supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005.

(7) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-060 Minimum benefit standards. The requirements of this section apply to Medicare supplement policies and certificates issued or issued for delivery in this state during the period beginning January 1, 1990, and ending June 30, 1992, as well as all guaranteed renewable Medicare supplement policies delivered to residents of this state during 1989 ~~((and which))~~ that were ((conformed)) modified to meet the minimum benefit standards of this section ((pursuant to)) under the Medicare Catastrophic Coverage Act. Minimum standards for "standardized" policies and certificates are provided ((at)) in WAC 284-66-063. ((Effective July 1, 1992, only policies meeting the standards of WAC 284-66-063 may be advertised, solicited, or issued for delivery in this state. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:))

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible;

(7) Coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-063 Benefit standards for policies or certificates issued or delivered (~~on or~~) after (~~July 1~~) June 30, 1992. (~~Only Medicare supplement policies or certificates meeting the requirements of this chapter may be delivered or issued for delivery in this state on or after July 1, 1992. After that date,~~) No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A Medicare supplement policy or certificate (~~shall~~) may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was

recommended by or received from a physician within three months before the effective date of coverage.

(b) ~~((No))~~ A Medicare supplement policy or certificate ~~((shall))~~ may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(c) Each Medicare supplement policy ~~((shall))~~ must be guaranteed renewable and:

(i) The issuer ~~((shall))~~ may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer ~~((shall))~~ may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the Medicare supplement policy is terminated by the group policy holder and is not replaced as provided under (c)(v) of this subsection, the issuer ~~((shall))~~ must offer certificateholders an individual Medicare supplement policy ~~((which))~~ that (at the option of the certificateholder) provides for continuation of the benefits contained in the group policy, or provides for ~~((such))~~ benefits ~~((as))~~ that otherwise meet~~((s))~~ the requirements of this subsection.

(iv) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer ~~((shall))~~ must offer the certificateholder the conversion opportunity described in (c)(iii) of this subsection, or at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(v) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy ~~((shall))~~ must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy ~~((shall))~~ may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(d) Termination of a Medicare supplement policy or certificate ~~((shall))~~ must be without prejudice to any continuous loss ~~((which commenced))~~ that began while the policy was in force, but the extension of benefits beyond the period ~~((during which))~~ that the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(e) If a Medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result

of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy or certificate is deemed to satisfy the guaranteed renewal requirements of this section.

(f)(i) A Medicare supplement policy or certificate (~~shall~~) must provide that benefits and premiums under the policy or certificate (~~shall~~) be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) (~~in which~~) that the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of (~~such~~) the policy or certificate within ninety days after the date the individual becomes entitled to (~~such~~) the assistance.

(ii) If (~~such~~) the suspension occurs and if the policyholder or certificateholder loses entitlement to (~~such~~) medical assistance, (~~such~~) the policy or certificate (~~shall~~) must be automatically reinstituted (~~(+)~~) effective as of the date of termination of (~~such~~) the entitlement (~~(+)~~ as of the termination of such entitlement)) if the policyholder or certificateholder provides notice of loss of (~~such~~) the entitlement within ninety days after the date of (~~such~~) the loss and pays the premium attributable to the period (~~(+)~~ effective as of the date of termination of such entitlement)).

(iii) Each Medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy must be automatically reinstituted (effective as of the date of loss of coverage within ninety days after the date of the loss).

(g) Reinstitution of (~~such~~) the coverages;

(~~(A) Shall~~) (i) May not provide for any waiting period with respect to treatment of preexisting conditions;

(~~(B) Shall~~) (ii) Must provide for resumption of coverage (~~which~~) that is substantially equivalent to coverage in effect before the date of (~~such~~) the suspension (~~(+)~~ and)). If the suspended Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

~~((C) Shall)~~ (iii) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(2) Standards for basic ("core") benefits common to ~~((all))~~ benefit plans A-J. Every issuer ~~((shall))~~ must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in ~~((lieu thereof))~~ place of the basic "core" package.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the ~~((diagnostic related group (DRG) day outlier per diem))~~ applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packaged red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital; outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(3) Standards for additional benefits. The following additional benefits ~~((shall))~~ must be included in Medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

(a) Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit

period for posthospital skilled nursing facility care eligible under Medicare Part A;

(c) Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the Medicare Part B excess charges: Coverage for eighty percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(e) One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare supplement policy after December 31, 2005.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare supplement policy after December 31, 2005.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, ~~((which care))~~ that would have been covered by Medicare if provided in the United States and ~~((which care))~~ that began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" ~~((shall))~~ means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by Medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from

~~((i))~~ (ii) of this subsection and patient education to address preventive health care measures.

(ii) ~~((Any one or a combination of the following))~~ Preventive screening tests or preventive services, the selection and frequency ~~((of which))~~ that is ~~((considered))~~ determined to be medically appropriate~~((+~~

~~(A) Fecal occult blood test and/or digital rectal examination;~~

~~(B) Mammogram;~~

~~(C) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria;~~

~~(D) Pure tone (air only) hearing screening test, administered or ordered by a physician;~~

~~(E) Serum cholesterol screening (every five years);~~

~~(F) Thyroid function test;~~

~~(G) Diabetes screening.~~

~~(iii) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every ten years).~~

~~(iv) Any other tests or preventive measures determined appropriate))~~ by the attending physician.

Reimbursement ~~((shall))~~ must be for the actual charges up to one hundred percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in *American Medical Association Current Procedural Terminology (AMA CPT)* codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit ~~((shall))~~ may not include payment for any procedure covered by Medicare.

(j) At-home recovery benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(i) For purposes of this benefit, the following definitions ~~((shall))~~ apply:

(A) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" ~~((shall))~~ means any place used by the insured as a place of residence, provided that ~~((such))~~ the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility ~~((shall))~~ is not ~~((be))~~ considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a

twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

(A) At-home recovery services provided must be primarily services ~~((which))~~ that assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits ~~((shall))~~ may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(iii) Coverage is excluded for: Home care visits paid for by Medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

~~((k) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.))~~ (3) Standardized Medicare supplement benefit plan "K" must consist of the following:

(a) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(b) Coverage of one hundred percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A deductible: Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (j) of this subsection;

(e) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (j) of this subsection;

(f) Hospice care: Coverage for fifty percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (j) of this subsection;

(g) Coverage for fifty percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (j) of this subsection;

(h) Except for coverage provided in (i) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (j) of this subsection;

(i) Coverage of one hundred percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(4) Standardized Medicare supplement benefit plan "L" must consist of the following:

(a) The benefits described in subsection (3)(a), (b), (c) and (i) of this section;

(b) The benefit described in subsection (3)(d), (e), (f) and (h) of this section but substituting seventy-five percent for fifty percent; and

(c) The benefit described in subsection (3)(j) of this section but substituting two thousand dollars for four thousand dollars.

AMENDATORY SECTION (Amending Order R 92-7, filed 8/19/92, effective 9/19/92)

WAC 284-66-066 Standard Medicare supplement benefit plans.

(1) An issuer (~~((shall))~~) must make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.

(2) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section (~~((shall))~~) may be offered for sale in this state, except as (~~((may be))~~) permitted in WAC (~~((284-66-063(3)(k)))~~) 284-66-066(7) and in WAC 284-66-073.

(3) Benefit plans (~~((shall))~~) must be uniform in structure, language, designation, and format to the standard benefit plans "A" through (~~((J))~~) "L" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit (~~((shall))~~) must be structured (~~((in accordance with))~~) according to the format provided in WAC 284-66-063(2) (~~((and 284-66-063(3)))~~), (3) or (4) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of benefit.

(4) An issuer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" (~~((shall))~~) must be limited to only the basic ("core") benefits common to all benefit plans, as defined (~~((at))~~) in WAC 284-66-063(2).

(b) Standardized Medicare supplement benefit plan "B" (~~((shall include))~~) consists of only the following: The core benefit as defined (~~((at))~~) in WAC 284-66-063(2), plus the

Medicare Part A deductible as defined ~~((at))~~ in WAC 284-66-063 (3)(a).

(c) Standardized Medicare supplement benefit plan "C" ~~((shall include))~~ consists of only the following: The core benefit as defined ~~((at))~~ in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined ~~((at))~~ in WAC 284-66-063 (3)(a), (b), (c), and (h), respectively.

(d) Standardized Medicare supplement plan "D" ~~((shall include))~~ consists of only the following: The core benefit, as defined ~~((at))~~ in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined ~~((at))~~ in WAC 284-66-063 (3)(a), (b), (h), and (j), respectively.

(e) Standardized Medicare supplement benefit plan "E" ~~((shall include))~~ consists of only the following: The core benefit as defined ~~((at))~~ in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined ~~((at))~~ in WAC 284-66-063 (3)(a), (b), (h), and (i), respectively.

(f) Standardized Medicare supplement benefit plan "F" ~~((shall include))~~ consists of only the following: The core benefit as defined ~~((at))~~ in WAC 284-66-063(2), plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined ~~((at))~~ in WAC 284-66-063 (3)(a), (b), (c), (e), and (h), respectively.

(g) Standardized Medicare supplement benefit high deductible plan "F" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e) and (h) respectively. The annual high deductible plan "F" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and must be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers

for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(h) Standardized Medicare supplement benefit plan "G" (~~shall include~~) consists of only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, eighty percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined (~~at~~) in WAC 284-66-063 (3)(a), (b), (d), (h), and (j), respectively.

(~~(h)~~) (i) Standardized Medicare supplement benefit plan "H" (~~shall include~~) consists of only the following: The core benefit as defined (~~at~~) in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined (~~at~~) in WAC 284-66-063 (3)(a), (b), (f), and (h), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(~~(i)~~) (j) Standardized Medicare supplement benefit plan "I" (~~shall include~~) consists of only the following: The core benefit as defined (~~at~~) in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined (~~at~~) in WAC 284-66-063 (3)(a), (b), (e), (f), (h), and (j), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(~~(j)~~) (k) Standardized Medicare supplement benefit plan "J" (~~shall include~~) consists of only the following: The core benefit as defined (~~at~~) in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined (~~at~~) in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(l) Standardized Medicare supplement benefit high deductible plan "J" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare

Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventative medical care benefit and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and must be in addition to any other specific benefit deductibles. The annual deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(6) Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA):

(a) Standardized Medicare supplement benefit plan "K" consists of only those benefits described in WAC 284-66-063(3).

(b) Standardized Medicare supplement benefit plan "L" consists of only those benefits described in WAC 284-66-063(4).

(7) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefits may not include an outpatient prescription drug benefit.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-073 Medicare SELECT policies and certificates.

(1)(a) This section (~~((shall apply))~~) applies to Medicare SELECT policies and certificates, as defined in this section.

(b) No policy or certificate may be advertised as a

Medicare SELECT policy or certificate unless it meets the requirements of this section.

(2) For the purposes of this section:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare SELECT issuer or its network providers.

(b) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare SELECT policy or certificate with the administration, claims practices, or provision of services concerning a Medicare SELECT issuer or its network providers.

(c) "Medicare SELECT issuer" means an issuer offering, or seeking to offer, a Medicare SELECT policy or certificate.

(d) "Medicare SELECT policy" or "Medicare SELECT certificate" means respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(e) "Network provider" means a provider of health care, or a group of providers of health care, (~~((which))~~) that has entered into a written agreement with the issuer to provide benefits insured under a Medicare SELECT policy.

(f) "Restricted network provision" means any provision (~~((which))~~) that conditions the payment of benefits, in whole or in part, on the use of network providers.

(g) "Service area" means the geographic area approved by the commissioner (~~((within which))~~) where an issuer is authorized to offer a Medicare SELECT policy.

(3) The commissioner may authorize an issuer to offer a Medicare SELECT policy or certificate, (~~((pursuant to))~~) under this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

(4) A Medicare SELECT issuer (~~((shall))~~) may not issue a Medicare SELECT policy or certificate in this state until its plan of operation has been approved by the commissioner.

(5) A Medicare SELECT issuer (~~((shall))~~) must file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation (~~((shall))~~) must contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) (~~((Such))~~) The services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care (~~((shall))~~) must reflect usual practice in the local area. Geographic availability (~~((shall))~~) must reflect the usual travel times within the community.

(ii) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(A) To deliver adequately all services that are subject to a restricted network provision; or

(B) To make appropriate referrals.

(iii) There are written agreements with network providers describing specific responsibilities.

(iv) Emergency care is available twenty-four hours per day and seven days per week.

(v) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting ~~((such))~~ the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare SELECT policy or certificate. This paragraph ~~((shall))~~ does not apply to supplemental charges or coinsurance amounts as stated in the Medicare SELECT policy or certificate.

(b) A statement or map providing a clear description of the service area.

(c) A description of the grievance procedure to be ~~((utilized))~~ used.

(d) A description of the quality assurance program, including:

(i) The formal organizational structure;

(ii) The written criteria for selection, retention, and removal of network providers; and

(iii) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(e) A list and description, by specialty, of the network providers.

(f) Copies of the written information proposed to be used by the issuer to comply with subsection (9) of this section.

(g) Any other information requested by the commissioner.

(6)(a) A Medicare SELECT issuer ~~((shall))~~ must file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner ~~((prior to))~~ before implementing ~~((such))~~ the changes. ~~((Such))~~ The changes ~~((shall))~~ will be considered approved by the commissioner after thirty days unless specifically disapproved.

(b) An updated list of network providers ~~((shall))~~ must be filed with the commissioner at least quarterly.

(7) A Medicare SELECT policy or certificate ~~((shall))~~ may not restrict payment for covered services provided by nonnetwork providers if:

(a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

(b) It is not reasonable to obtain (~~such~~) the services through a network provider.

(8) A Medicare SELECT policy or certificate (~~shall~~) must provide payment for full coverage under the policy for covered services that are not available through network providers.

(9) A Medicare SELECT issuer (~~shall~~) must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare SELECT policy or certificate to each applicant. This disclosure (~~shall~~) must include at least the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare SELECT policy or certificate with:

(i) Other Medicare supplement policies or certificates offered by the issuer; and

(ii) Other Medicare SELECT policies or certificates.

(b) A description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are (~~utilized~~) used.

(d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(e) A description of limitations on referrals to restricted network providers and to other providers.

(f) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(g) A description of the Medicare SELECT issuer's quality assurance program and grievance procedure.

(10) (~~Prior to~~) Before the sale of a Medicare SELECT policy or certificate, a Medicare SELECT issuer (~~shall~~) must obtain from the applicant a signed and dated form stating that the applicant has received the information provided (~~pursuant to~~) under subsection (9) of this section and that the applicant understands the restrictions of the Medicare SELECT policy or certificate.

(11) A Medicare SELECT issuer (~~shall~~) must have and use procedures for hearing complaints and resolving written grievances from the subscribers. (~~Such~~) The procedures

~~((shall))~~ must be aimed at mutual agreement for settlement and may include arbitration procedures.

(a) The grievance procedure ~~((shall))~~ must be described in the policy and certificates and in the outline of coverage.

(b) At the time the policy or certificate is issued, the issuer ~~((shall))~~ must provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(c) Grievances ~~((shall))~~ must be considered in a timely manner and ~~((shall))~~ must be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(d) If a grievance is found to be valid, corrective action ~~((shall))~~ must be taken promptly.

(e) All concerned parties ~~((shall))~~ must be notified about the results of a grievance.

(f) The issuer ~~((shall))~~ must report no later than each March 31st to the commissioner regarding its grievance procedure. The report ~~((shall))~~ must be in a format prescribed by the commissioner and ~~((shall))~~ must contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of ~~((such))~~ the grievances.

(12) At the time of initial purchase, a Medicare SELECT issuer ~~((shall))~~ must make available to each applicant for a Medicare SELECT policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(13)(a) At the request of an individual insured under a Medicare SELECT policy or certificate, a Medicare SELECT issuer ~~((shall))~~ must make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer ~~((which))~~ that has comparable or lesser benefits and ~~((which))~~ does not contain a restricted network provision. The issuer ~~((shall))~~ must make ~~((such))~~ the policies or certificates available without requiring evidence of insurability after the Medicare supplement policy or certificate has been in force for ~~((six))~~ three months.

(b) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare SELECT policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, ~~((coverage for prescription drugs,))~~ coverage for at-home recovery services, or coverage for Part B excess charges.

(14) Medicare SELECT policies and certificates ~~((shall))~~ must provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare SELECT

policies and certificates issued (~~((pursuant to))~~) under this section should be discontinued due to either the failure of the Medicare SELECT program to be reauthorized under law or its substantial amendment.

(a) Each Medicare SELECT issuer (~~((shall))~~) must make available to each individual insured under a Medicare SELECT policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer (~~((which))~~) that has comparable or lesser benefits and (~~((which))~~) does not contain a restricted network provision. The issuer (~~((shall))~~) must make (~~((such))~~) the policies and certificates available without requiring evidence of insurability.

(b) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare SELECT policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, (~~((coverage for prescription drugs,))~~) coverage for at-home recovery services, or coverage for Part B excess charges.

(15) A Medicare SELECT issuer (~~((shall))~~) must comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare SELECT program.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-080 Outline of coverage required. (1) Issuers (~~((shall))~~) must provide an outline of coverage to all applicants at the time an application is presented to the prospective applicant and, except for direct response policies and certificates, (~~((shall))~~) must obtain an acknowledgement of receipt of (~~((such))~~) the outline from the applicant.

(2) The "outline of coverage," (~~((shall))~~) must be completed in substantially the form set forth in WAC 284-66-092. The form of outline of coverage (~~((shall))~~) must be filed with the commissioner (~~((prior to use))~~) before being used in this state.

(3) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis (~~((which))~~) that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany (~~((such))~~) the policy or

certificate when it is delivered and contain the following statement, in no less than twelve point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(4) The outline of coverage provided to applicants (~~((pursuant to))~~) set forth in this section consists of four parts: A cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage (~~((shall))~~) must be in the language and format prescribed in WAC 284-66-092 in no less than twelve point type. All plans (~~((A-J shall))~~) A-L must be shown on the cover page, and the plan(s) that are offered by the issuer (~~((shall))~~) must be prominently identified. Premium information for plans that are offered (~~((shall))~~) must be shown on the cover page or immediately following the cover page and (~~((shall))~~) must be prominently displayed. The premium and mode (~~((shall))~~) must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant (~~((shall))~~) must be illustrated.

(5) Where inappropriate terms are used, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor, or health maintenance organization (~~((shall))~~) must substitute appropriate terminology.

AMENDATORY SECTION (Amending Order R 92-7, filed 8/19/92, effective 9/19/92)

WAC 284-66-092 Form of "outline of coverage." (1) Cover page.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s)____[insert letter(s) of plan(s) being offered]
See Outlines of Coverage sections for details about ALL plans

~~((Medicare supplement insurance can be sold in only ten standard plans. This))~~ These charts show((s)) the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

~~((BASIC BENEFITS: Included in All Plans.))~~ **Basic Benefits for Plans A-J**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F/F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							((Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (3,000 Limit))
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as plans F and J after one has paid a calendar year [\$] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [\$]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[Company Name] does not offer the [high deductible plan F] [high deductible plan J] [high deductible plan F or J].

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
<u>Basic Benefits</u>	<u>100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End</u> <u>50% Hospice cost-sharing</u> <u>50% of Medicare-eligible expenses for the first three pints of blood</u> <u>50% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services</u>	<u>100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End</u> <u>75% Hospice cost-sharing</u> <u>75% of Medicare-eligible expenses for the first three pints of blood</u> <u>75% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services</u>
<u>Skilled Nursing Coinsurance</u>	<u>50% Skilled Nursing Facility Coinsurance</u>	<u>75% Skilled Nursing Facility Coinsurance</u>
<u>Part A Deductible</u>	<u>50% Part A Deductible</u>	<u>75% Part A Deductible</u>
<u>Part B Deductible</u>		
<u>Part B Excess (100%)</u>		

<u>Foreign Travel Emergency</u>		
<u>At-Home Recovery</u>		
<u>Preventative Care NOT covered by Medicare</u>		
	<u>\$[] Out-of-Pocket Annual Limit***</u>	<u>\$[] Out-of-Pocket Annual Limit***</u>

**Plan K and L provide for different cost-sharing for items and services A-J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

(2) Disclosure page(s) :

PREMIUM INFORMATION [Boldface Type]

We, [insert issuer's name], can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult ((The Medicare Handbook)) Medicare and you for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy

and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts (~~((pursuant to))~~) as noted in WAC 284-66-066(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

(3) Charts displaying the feature of each benefit plan offered by the issuer:

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$ ((652)) <input type="text"/>	\$0	\$ ((652)) <input type="text"/> (Part A deductible)
61st thru 90th day	All but \$ ((163)) <input type="text"/> a day	\$ ((163)) <input type="text"/> a day	\$0
91st day and after:			
--- While using 60 lifetime reserve days	All but \$ ((326)) <input type="text"/> a day	\$ ((326)) <input type="text"/> a day	\$0
--- Once lifetime reserve days are used:			
--- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
--- Beyond the additional 365 days	\$0	\$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but ((\$81.50)) \$[]/day \$0	\$0 \$0 \$0	\$0 Up to ((\$81.50)) \$[] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	((\$100)) \$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 ((\$100)) \$[] (Part B deductible) \$0

CLINICAL LABORATORY SERVICES-- ((BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
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PLAN A
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First (((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 (((\$100)) \$[] (Part B deductible) \$0
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PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but (((\$652)) \$[] All but (((\$163)) \$[] a day All but (((\$326)) \$[] a day \$0 \$0	(((\$652)) \$[] (Part A deductible) (((\$163)) \$[] a day (((\$326)) \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day	All approved amounts All but (((\$81.50)) \$[]/day	\$0 \$0	\$0 Up to (((\$81.50)) \$[] a day

101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	((\$100)) \$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 ((\$100)) \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES- -((BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN B
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First (\$100) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 (\$100) \$[] (Part B deductible) \$0
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PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but (\$652) \$[] All but (\$163) \$[] a day All but (\$326) \$[] a day \$0 \$0	(\$652) \$[] (Part A deductible) (\$163) \$[] a day (\$326) \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but (\$81.50) \$[]/day \$0	\$0 Up to (\$81.50) \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100)) \$[] of Medicare approved amounts*	\$0	((\$100)) \$[] (Part B deductible)	\$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next ((\$100)) \$[] of Medicare approved amounts*	\$0	((\$100)) \$[] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES- ((BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN C

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment First ((\$100)) \$[] of Medicare approved amounts*	\$0	((\$100)) \$[] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0

PLAN C (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but (((\$652))) \$[] All but (((\$163))) \$[] a day All but (((\$326))) \$[] a day \$0 \$0	(((\$652))) \$[] (Part A deductible) (((\$163))) \$[] a day (((\$326))) \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but (((\$81.50))) \$[]/day \$0	\$0 Up to (((\$81.50))) \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance
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****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	((\$100)) \$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 ((\$100)) \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES--((BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0

- - - Durable medical equipment	\$0	\$0	((\$100)) E \$[] (Part B deductible) \$0
First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	80%	20%	
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after:	All but ((\$652)) \$[] All but ((\$163)) \$[] a day All but ((\$326)) \$[] a day	((\$652)) \$[] (Part A deductible) ((\$163)) \$[] a day ((\$326)) \$[] a day	\$0 \$0 \$0
- - - While using 60 lifetime reserve days			

- - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	\$0 \$0	100% of Medicare eligible expenses \$0	\$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but (((\$81.50)) \$[]/day \$0	\$0 Up to (((\$81.50)) \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~) \$[]) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100) \$[]) of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	((\$100) \$[]) (Part B deductible) \$0

Part B excess charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next (((\$100)) \$[] of Medicare approved amounts*	\$0	\$0	(((\$100)) \$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--((BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN E
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment First (((\$100)) \$[] of Medicare approved amounts*	\$0	\$0	(((\$100)) \$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

PLAN E (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

***PREVENTIVE MEDICARE CARE BENEFIT - NOT COVERED BY MEDICARE <u>Some annual physical and preventive tests and services ((such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education,)) administered or ordered by your doctor when not covered by Medicare</u> First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs
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***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but ((\$[652])) \$[] All but ((\$[163])) \$[] a day All but ((\$[326])) \$[] a day \$0 \$0	(((\$[652])) \$[] (Part A deductible) (((\$[163])) \$[] a day (((\$[326])) \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but (((\$81.50))) \$[]/day \$0	\$0 Up to (((\$81.50))) \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as plan F after one has paid a calendar year \$[] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE, **] YOU PAY
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MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	((\$100)) \$[] (Part B deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs ((\$100)) \$[] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES- ((BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[PLAN F] [HIGH DEDUCTIBLE PLAN F]
PARTS A & B

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY \$[] DEDUCTIBLE, **] PLAN PAYS</u>	<u>[IN ADDITION TO \$[] DEDUCTIBLE, **] YOU PAY</u>
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 ((\$100)) \$[] (Part B deductible) 20%	\$0 \$0 \$0

PLAN F (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY \$[] DEDUCTIBLE, **] PLAN PAYS</u>	<u>[IN ADDITION TO \$[] DEDUCTIBLE, **] YOU PAY</u>
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FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but ((652)) \$[] All but ((163)) \$[] a day All but ((326)) \$[] a day \$0 \$0	((652)) \$[] (Part A deductible) ((163)) \$[] a day ((326)) \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but ((81.50)) \$[]/day \$0	\$0 Up to ((81.50)) \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 80%	((\$100)) \$[] (Part B deductible) \$0 20%
BLOOD First 3 pints Next ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 ((\$100)) \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES- -(BLOOD) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 ((\$100)) \$[] (Part B deductible) \$0

AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
--- Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
--- Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
--- Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after:	All but ((\$[652])) \$[]	((\$[652])) \$[] (Part A deductible)	\$0
--- While using 60 lifetime reserve days	All but ((\$[163])) \$[] a day	((\$[163])) \$[] a day	\$0
--- Once lifetime reserve days are used:	All but ((\$[326])) \$[] a day	((\$[326])) \$[] a day	\$0
--- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
--- Beyond the additional 365 days	\$0	\$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but ((\$81.50)) \$[]/day \$0	\$0 Up to ((\$81.50)) \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 100%	((\$100)) \$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next ((\$100)) \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 ((\$100)) \$[] (Part B deductible) \$0

CLINICAL LABORATORY SERVICES- ((BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
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PLAN H
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment First ((\$100)) \$[] of Medicare approved amounts*	\$0	\$0	((\$100)) \$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

PLAN H (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
((BASIC OUTPATIENT PRESCRIPTION DRUGS — NOT COVERED BY MEDICARE First \$250 each calendar year Next \$2,500 each calendar year Over \$2,500 each calendar year	\$0 \$0 \$0	\$0 50% — \$1,250 calendar year maximum benefit \$0	\$250 50% All costs))

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but (((\$[652]))) \$[] All but (((\$[163]))) \$[] a day All but (((\$[326]))) \$[] a day \$0 \$0	(((\$[652]))) \$[] (Part A deductible) (((\$[163]))) \$[] a day (((\$[326]))) \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but (((\$[81.50]))) \$[]/day \$0	\$0 Up to (((\$[81.50]))) \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~(\$100)~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First (((\$100))) \$[] of Medicare approved amounts*	\$0	\$0	(((\$100))) \$[] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare approved amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next (((\$100))) \$[] of Medicare approved amounts*	\$0	\$0	(((\$100))) \$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--(BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN I (continued)
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment First (((\$100))) \$[] of Medicare approved amounts*	\$0	\$0	(((\$100))) \$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	

--- Calendar year maximum	\$0	\$1,600	
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OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges*	\$0	\$0	\$250
	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
((BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each calendar year Next \$2,500 each calendar year Over \$2,500 each calendar year	\$0 \$0 \$0	\$0 50% - \$1,250 calendar year maximum benefit \$0	\$250 50% All costs))

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year \$[] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Parts A and B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	<u>[AFTER YOU PAY \$[] DEDUCTIBLE, **]</u> PLAN PAYS	<u>[IN ADDITION TO \$[] DEDUCTIBLE, **]</u> YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used:	All but ((\$[652])) \$[] All but ((\$[163])) \$[] a day All but ((\$[326])) \$[] a day	((\$[652])) \$[] (Part A deductible) ((\$[163])) \$[] a day ((\$[326])) \$[] a day	\$0 \$0 \$0

- - - Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- - - Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but ((\$81.50)) \$[]/day \$0	\$0 Up to ((\$81.50)) \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[PLAN J] [HIGH DEDUCTIBLE PLAN J]
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed ((~~\$100~~)) \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year \$[] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and B, but does not include the plan's separate foreign travel emergency deductible]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ((\$100)) \$[] of Medicare approved amounts*	\$0	((\$100)) \$[] (Part B deductible)	\$0

Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare approved amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next ((\$100)) \$[] of Medicare approved amounts*	\$0	((\$100)) \$[] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--((BLOOD)) TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[PLAN J] [HIGH DEDUCTIBLE PLAN J] (continued)

PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE	100%	\$0	\$0
MEDICARE APPROVED SERVICES			
--- Medically necessary skilled care services and medical supplies			
--- Durable medical equipment	\$0	((\$100)) \$[] (Part B deductible)	\$0
First ((\$100)) \$[] of Medicare approved amounts*			
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
--- Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
--- Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
--- Calendar year maximum	\$0	\$1,600	

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0	\$0	\$250
((EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each calendar year Next \$6,000 each calendar year Over \$6,000 each calendar year	\$0 \$0 \$0	80% to a lifetime maximum benefit of \$50,000 50% — \$3,000 calendar year maximum benefit \$0	20% and amounts over the \$50,000 lifetime maximum 50% All costs))
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services ((such as: Fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education,)) administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[] each calendar year. The amounts that count toward your annual limit are noted with diamonds (.) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION* <u>Semiprivate room and board,</u> <u>general nursing and miscellaneous</u> <u>services and supplies</u> <u>First 60 days</u>	<u>All but \$[]</u>	<u>\$[] (50% of Part A deductible)</u>	<u>\$[] (50% of Part A deductible),</u>

<u>61st thru 90th day</u>	<u>All but \$[] a day</u>	<u>\$[] a day</u>	<u>\$0</u>
<u>91st day and after:</u>			
<u>- - - While using 60 lifetime reserve days</u>	<u>All but \$[] a day</u>	<u>\$[] a day</u>	<u>\$0</u>
<u>- - - Once lifetime reserve days are used:</u>			
<u>- - - Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare eligible expenses</u>	<u>\$0***</u>
<u>- - - Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>SKILLED NURSING FACILITY CARE*</u> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>First 20 days</u>			
<u>21st thru 100th day</u>	<u>All but \$[]/day</u>	<u>Up to \$[] a day</u>	<u>Up to \$[] a day,</u>
<u>101st day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>BLOOD</u>	<u>\$0</u>	<u>50%</u>	<u>50%,</u>
<u>First 3 pints</u>			
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>HOSPICE CARE</u> <u>Available as long as your doctor certifies you are terminally ill and you elect to receive these services</u>	<u>Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care</u>	<u>50% of coinsurance or copayments</u>	<u>50% of coinsurance or copayments,</u>

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

***Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u>MEDICAL EXPENSES -</u> <u>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,</u> <u>First \$[] of Medicare approved amounts****</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[] (Part B deductible)****,</u>

<u>Preventative Benefits for Medicare covered services</u>	<u>Generally 75% or more of Medicare approved amounts</u> <u>Generally 80%</u>	<u>Remainder of Medicare approved amounts</u> <u>Generally 10%</u>	<u>All costs above Medicare approved amounts</u> <u>Generally 10%,</u>
<u>Remainder of Medicare approved amounts</u> <u>Part B excess charges</u> <u>(Above Medicare approved amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs (and they do not count toward annual out-of-pocket limit of \$[])*</u>
<u>BLOOD</u> <u>First 3 pints</u> <u>Next \$[] of Medicare approved amounts****</u> <u>Remainder of Medicare approved amounts</u>	<u>\$0</u> <u>\$0</u> <u>Generally 80%</u>	<u>50%</u> <u>\$0</u> <u>Generally 10%</u>	<u>50%,</u> <u>\$[] (Part B deductible)****,</u> <u>Generally 10%,</u>
<u>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K (continued)
PARTS A & B

<u>SERVICE</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u>HOME HEALTH CARE</u> <u>MEDICARE APPROVED</u> <u>SERVICES</u> <u>- - - Medically necessary skilled</u> <u>care services and medical</u> <u>supplies</u> <u>- - - Durable medical equipment</u> <u>First \$[] of Medicare</u> <u>approved amounts*****</u> <u>Remainder of Medicare</u> <u>approved amounts</u>	<u>100%</u> <u>\$0</u> <u>80%</u>	<u>\$0</u> <u>\$0</u> <u>10%</u>	<u>\$0</u> <u>\$[] (Part B deductible),</u> <u>10%,</u>

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[] each calendar year. The amounts that count toward your annual limit are noted with diamonds (,) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
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<u>HOSPITALIZATION***</u> <u>Semiprivate room and board,</u> <u>general nursing and miscellaneous</u> <u>services and supplies</u> <u>First 60 days</u> <u>61st thru 90th day</u> <u>91st day and after:</u> <u>- - - While using 60 lifetime</u> <u>reserve days</u> <u>- - - Once lifetime reserve</u> <u>days are used:</u> <u>- - - Additional 365 days</u> <u>- - - Beyond the</u> <u>additional</u> <u>365 days</u>	<u>All but \$[]</u> <u>All but \$[] a day</u> <u>All but \$[] a day</u> <u>\$0</u> <u>\$0</u>	<u>\$[] (75% of Part A</u> <u>deductible)</u> <u>\$[] a day</u> <u>\$[] a day</u> <u>100% of Medicare</u> <u>eligible expenses</u> <u>\$0</u>	<u>\$[] (25% of Part</u> <u>A</u> <u>deductible),</u> <u>\$0</u> <u>\$0</u> <u>\$0***</u> <u>All costs</u>
<u>SKILLED NURSING FACILITY</u> <u>CARE*</u> <u>You must meet Medicare's</u> <u>requirements, including having</u> <u>been in a hospital for at least 3</u> <u>days and entered a Medicare-</u> <u>approved facility within 30 days</u> <u>after leaving the hospital</u> <u>First 20 days</u> <u>21st thru 100th day</u> <u>101st day and after</u>	<u>All approved amounts</u> <u>All but \$[]/day</u> <u>\$0</u>	<u>\$0</u> <u>Up to \$[] a day</u> <u>\$0</u>	<u>\$0</u> <u>Up to \$[] a day,</u> <u>All costs</u>
<u>BLOOD</u> <u>First 3 pints</u> <u>Additional amounts</u>	<u>\$0</u> <u>100%</u>	<u>75%</u> <u>\$0</u>	<u>25%,</u> <u>\$0</u>
<u>HOSPICE CARE</u> <u>Available as long as your doctor</u> <u>certifies you are terminally ill and</u> <u>you elect to receive these services</u>	<u>Generally, most Medicare</u> <u>eligible expenses for</u> <u>outpatient drugs and</u> <u>inpatient respite care</u>	<u>75% of coinsurance or</u> <u>copayments</u>	<u>75% of coinsurance</u> <u>or copayments,</u>

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY *</u>
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AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-110 Buyer's guide. (1) Issuers of disability insurance policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare must provide to all such applicants the pamphlet "Guide to Health Insurance for People with Medicare," developed jointly by the National Association of Insurance Commissioners and ~~((Health Care Financing Administration))~~ the Centers for Medicare and Medicaid Services, (CMS), or any reproduction or official revision of that pamphlet. The guide ~~((shall))~~ must be printed in a style and with a type character that is easily read by an average person eligible for Medicare supplement insurance and in no case may the type size be smaller than 12-point type. (Specimen copies may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C.)

(2) Delivery of the guide ~~((shall))~~ must be made whether or not ~~((such))~~ the policies or certificates are advertised, solicited, or issued as Medicare supplement insurance policies or certificates.

(3) Except in the case of a direct response issuers, delivery of the guide ~~((shall))~~ must be made to the applicant at the time of application and acknowledgement of receipt of the guide ~~((shall))~~ must be obtained by the issuer. Direct response issuers ~~((shall))~~ must deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

(4) The guide ~~((shall))~~ must be reproduced in a form that is substantially identical in language, format, type size, type proportional spacing, bold character, and line spacing to the guide developed jointly by the National Association of Insurance Commissioners and ~~((the Health Care Financing Administration))~~ CMS.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-120 Notice regarding policies ~~((which))~~ that are not Medicare supplement policies. Any disability insurance policy or certificate (other than a Medicare supplement policy or certificate or a policy issued ~~((pursuant))~~ according to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.)), disability income protection policy or other policy identified in RCW 48.66.020(1), whether issued on an individual or group basis, ~~((which policy))~~ that purports to provide coverage to residents of this state eligible for Medicare, ~~((shall))~~ must notify policyholders or certificate holders that the policy is not a Medicare supplement insurance policy or certificate. The notice ~~((shall))~~ must be printed or attached to the first page of the outline of coverage or equivalent disclosure form, and ~~((shall))~~ must be delivered to the policyholder or certificate holder. If no outline of coverage is delivered, the notice ~~((shall))~~ must be attached to the first page of the policy or certificate delivered to insureds. ~~((Such))~~ The notice ~~((shall))~~ must be in no less than twelve point type and ~~((shall))~~ contain the following language: "This (policy, certificate or subscriber contract) is not a Medicare supplement (policy, certificate or subscriber contract). If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company."

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-130 Requirements for application forms and replacement of Medicare supplement insurance coverage. (1)

Application forms (~~((shall))~~) must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance or other disability policy or certificate in force or whether a Medicare supplement insurance policy or certificate is intended to replace any other policy or certificate of a health care service contractor, health maintenance organization, disability insurer, or fraternal benefit society presently in force. A supplementary application or other form to be signed by the applicant and agent containing (~~((such))~~) the questions and statements, may be used: (~~((Provided, however, That where))~~) If the coverage is sold without an agent, the supplementary application (~~((shall))~~) must be signed by the applicant.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) If you are sixty-five or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended if requested during your entitlement to benefits under Medicaid for twenty-four months. You must request this suspension within ninety days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the

reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge.

~~(1) ((Do you have another Medicare supplement policy or certificate in force?~~

~~(a) If so, with which company?~~

~~(b) If so, do you intend to replace your current Medicare supplemental policy with this policy or certificate?~~

~~(2) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?~~

~~(a) If so, with which company?~~

~~(b) What kind of policy?~~

~~(3) Are you covered for medical assistance through the state Medicaid program:~~

~~(a) As a "Specified Low-Income Medicare Beneficiary" (SLMB)?~~

~~(b) As a "Qualified Medicare Beneficiary" (QMB)?~~

~~(c) For other Medicaid medical benefits?)~~ (a) Did you turn age 65 in the last 6 months?

Yes ☐

No ☐

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes ☐

No ☐

(c) If yes, what is the effective date?

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT; If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes ☐

No ☐

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes ☐

No ☐

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes ☐

No ☐

(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START //

END //

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes ☐

No ☐

(c) Was this your first time in this type of Medicare plan?

Yes ☐

No ☐

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes ☐

No ☐

(4) (a) Do you have another Medicare supplement policy in force?

Yes ☐

No ☐

(b) If so, with what company and what plan do you have [optional for Direct Mailers]?

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes ☐

No ☐

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.)

Yes ☐

No ☐

(a) If so, with what company and what kind of policy?

(b) What are your dates of coverage under the other policy?

START //

END //

(If you are still covered under the other policy, leave "END" blank.)

(2) Agents (~~((shall))~~) must list any other medical or health insurance policies sold to the applicant.

(a) List policies sold (~~((which))~~) that are still in force.

(b) List policies sold in the past five years (~~((which))~~) that are no longer in force.

(3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, (~~((shall))~~) must be returned to the applicant by the insurer upon delivery of the policy.

(4) Upon determining that a sale will involve replacement of Medicare Supplement Coverage, an issuer, other than a direct response issuer, or its agent, (~~((shall))~~) must furnish the applicant, (~~((prior to issuance or delivery of))~~) before issuing or delivering the Medicare supplement insurance policy or certificate, a notice regarding replacement of Medicare supplement insurance coverage. One copy of (~~((such))~~) the notice, signed by the applicant and the agent (except where the coverage is sold without an agent), (~~((shall))~~) must be provided to the applicant and an additional signed copy (~~((shall))~~) must be (~~((retained))~~) kept by the issuer. A direct response issuer (~~((shall))~~) must deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement insurance coverage.

(5) The notice required by subsection (4) of this section for an issuer, (~~((shall))~~) must be provided in substantially the form set forth in WAC 284-66-142 in no smaller than twelve point type, and (~~((shall))~~) must be filed with the commissioner (~~((prior to use))~~) before being used in this state.

(6) The notice required by subsection (4) of this section for a direct response insurer (~~((shall))~~) must be in substantially the form set forth in WAC 284-66-142 and (~~((shall))~~) must be filed with the commissioner (~~((prior to use))~~) before being used in this state.

(7) A true copy of the application for a Medicare supplement insurance policy issued by a health maintenance organization or health care service contractor for delivery to a resident of this state must be attached to or otherwise physically made a part of the policy when issued and delivered.

(8) Where inappropriate terms are used, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor or health maintenance organization may substitute appropriate terminology.

(9) Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an

issuer if the replacement does not involve application of a new preexisting condition limitation.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-135 Disclosure statements to be used with policies that are not Medicare supplement policies. Applications for the purchase of disability or other medical insurance policies or certificates, that are provided to persons eligible for Medicare, (~~((shall))~~) must disclose the extent to which the policy duplicates Medicare. The disclosure (~~((shall))~~) must be in the form provided by this section. The applicable disclosure statement (~~((shall))~~) must be provided as a part of, or together with, the application for the policy or certificate.

(1) Instructions for use of the disclosure statements for health insurance policies sold to Medicare beneficiaries that duplicate Medicare.

(a) (~~((Federal law, P.L. 103-432,))~~) Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a disability or other health insurance policy (the term "policy" or "policies" includes certificates and contracts of all issuers) that duplicate Medicare benefits unless it will pay benefits without regard to other disability or other health coverage and it includes the prescribed disclosure statement on or together with the application.

(b) All types of disability or other health insurance policies that duplicate Medicare (~~((shall))~~) must include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary substantially from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

(c) State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.

(d) Property/casualty and life insurance policies are not considered disability or other health insurance.

(e) Disability income policies are not considered to provide benefits that duplicate Medicare.

(f) Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

(g) The federal law does not preempt state laws that are more stringent than the federal requirements.

~~((g))~~ (h) The federal law does not preempt existing state form filing requirements.

(2) **Disclosure statement to be used for policies that provide benefits for expenses incurred for accidental injury only.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

☐ hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

☐ hospitalization
☐ physician services
☐ [outpatient prescription drugs if you are enrolled in Medicare Part D]
☐ other approved items and services

Before You Buy This Insurance

/ Check the coverage in **all** health insurance policies you already have.
/ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
/ For help in understanding your health insurance, contact your state insurance department or state ~~((senior))~~ health insurance ((counseling)) assistance program [SHIP].

(3) **Disclosure statement to be used with policies that provide benefits for specified limited services.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- ☐ any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- ☐ hospitalization
- ☐ physician services
- ☐ [outpatient prescription drugs if you are enrolled in Medicare Part D]
- ☐ other approved items and services

Before You Buy This Insurance

- / Check the coverage in **all** health insurance policies you already have.
- / For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- / For help in understanding your health insurance, contact your state insurance department or state ~~((senior))~~ health insurance ((counseling)) assistance program [SHIP].

(4) **Disclosure statement to be used with policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are

treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- ☐ hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- ☐ hospitalization
- ☐ physical services
- ☐ hospice
- ☐ [outpatient prescription drugs if you are enrolled in Medicare Part D]
- ☐ other approved items and services

Before You Buy This Insurance

- / Check the coverage in **all** health insurance policies you already have.
- / For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- / For help in understanding your health insurance, contact your state insurance department or state ~~((senior))~~ health insurance ((counseling)) assistance program [SHIP].

(5) Disclosure statement to be used with policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- ☐ hospitalization
- ☐ physician services
- ☐ hospice
- ☐ [outpatient prescription drugs if you are enrolled in Medicare Part D]
- ☐ other approved items and services

Before You Buy This Insurance

- / Check the coverage in **all** health insurance policies you already have.
- / For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- / For help in understanding your health insurance, contact your state insurance department or state ((~~senior~~)) health insurance ((~~counseling~~)) assistance program [SHIP].

(6) Disclosure statement to be used with indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- ☐ any expenses or service covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- ☐ hospitalization

- ☐ physician services
- ☐ [outpatient prescription drugs if you are enrolled in Medicare Part D]
- ☐ hospice
- ☐ other approved items & services

Before You Buy This Insurance

- / Check the coverage in **all** health insurance policies you already have.
- / For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- / For help in understanding your health insurance, contact your state insurance department or state ((~~senior~~)) health insurance ((~~counseling~~)) assistance program [SHIP].

(7) Disclosure statement to be used with policies that provide benefits for both expenses incurred and fixed indemnity basis.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- ☐ any expenses or service covered by the policy are also covered by Medicare; or
- ☐ it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- ☐ hospitalization
- ☐ physician services
- ☐ [outpatient prescription drugs if you are enrolled in Medicare Part D]

- hospice care
- other approved items & services

Before You Buy This Insurance

- / Check the coverage in **all** health insurance policies you already have.
- / For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- / For help in understanding your health insurance, contact your state insurance department or state ((~~senior~~)) health insurance ((~~counseling~~)) assistance program [SHIP].

(8) **Disclosure statement to be used with long-term care policies providing both nursing home and noninstitutional coverage.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long-term care expenses.

Before You Buy This Insurance

- / Check the coverage in **all** health insurance policies you already have.
- / For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.

- / For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- / For help in understanding your health insurance, contact your state insurance department or state ((~~senior~~)) health insurance ((~~counseling~~)) assistance program [SHIP].

(9) Disclosure statement to be used with policies providing nursing home benefits only.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

- / Check the coverage in **all** health insurance policies you already have.
- / For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
- / For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- / For help in understanding your health insurance, contact your state insurance department or state ((~~senior~~)) health insurance ((~~counseling~~)) assistance program [SHIP].

(10) Disclosure statement to be used with policies providing home care benefits only.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

- / Check the coverage in **all** health insurance policies you already have.
- / For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
- / For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- / For help in understanding your health insurance, contact your state insurance department or state ((~~senior~~)) health insurance ((~~counseling~~)) assistance program [SHIP].

(11) Disclosure statement to be used with other health insurance policies not specifically identified in the previous statements.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- ☐ hospitalization
- ☐ physician services
- ☐ [outpatient prescription drugs if you are enrolled in Medicare Part D]
- ☐ hospice
- ☐ other approved items and services

Before You Buy This Insurance

/ Check the coverage in **all** health insurance policies you already have.

/ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

/ For help in understanding your health insurance, contact your state insurance department or state ((~~senior~~)) health insurance ((~~counseling~~)) assistance program [SHIP].

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-142 Form of replacement notice.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR
MEDICARE ADVANTAGE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company name] Insurance Company. Your new policy will provide thirty days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other disability coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

Additional benefits.

No change in benefits, but lower premiums.

Fewer benefits and lower premiums.

My plan has outpatient prescription drug coverage and I am enrolling in Part D.

Disenrollment from a Medicare Advantage plan.

Please explain reason for disenrollment. [optional only for Direct Mailers]

Other. (please specify)

1. NOTE: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. If you have had your current Medicare supplement policy less than ((~~six~~)) three months, health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker, or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

.....
(Applicant's Signature)

.....
(Date)

*Signature not required for direct response sales.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92,
effective 3/27/92)

WAC 284-66-160 Adjustment notice to conform existing Medicare supplement policies to changes in Medicare. As soon as practicable, but no later than thirty days (~~((prior to))~~) before the effective date of any Medicare benefit changes, every insurer providing Medicare supplement insurance coverage to a resident of this state (~~((shall))~~) must notify its insureds of modifications it has made to Medicare supplement policies. The adjustment notice is intended to be informational only and for the sole purpose of informing policyholders and certificate holders about changes in Medicare benefits, indexed deductible and copayment provisions, premium adjustments, and the like. The form of an adjustment notice provided to residents of this state (~~((shall))~~) must be filed with the commissioner (~~((prior to use))~~) before being used.

(1) The notice (~~((shall))~~) must include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy.

(2) The notice (~~((shall))~~) must inform each covered person of the approximate date when premium adjustments due to changes in Medicare benefits will be made.

(3) The notice of benefit modifications and any premium changes (~~((shall))~~) must be furnished in outline form and in clear and simple terms so as to facilitate comprehension.

(4) The notice (~~((shall))~~) must not contain or be accompanied by any solicitation.

(5) Issuers must comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-170 Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates. (1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer (~~((shall))~~) must waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent (~~((such))~~) the time was spent under the original policy.

(2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate (~~((which))~~) that has been in effect for at least (~~((six))~~) three months, the replacing policy (~~((shall))~~) may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-200 Standards for loss ratios. The following standards apply to policies issued or delivered (~~((prior to))~~) before July 1, 1992, unless (~~((such))~~) the policies are approved under the standards of WAC 284-66-063 and 284-66-203. Medicare supplement insurance policies (~~((shall))~~) must return to policyholders in the form of aggregated benefits under (~~((such))~~) the policy, for the entire period for which rates are computed to provide coverage, loss ratios not less than those (~~((set forth))~~) in this section. (~~((Such))~~) The loss ratios (~~((shall))~~) must be on the basis of incurred claims losses and earned premiums for such period (~~((in accordance with))~~) according to accepted actuarial principles. The loss ratio standards of this section are more stringent and more appropriate than those imposed by RCW 48.66.100, and are necessary for the protection of the public interest.

(1) Where coverage is provided on a service rather than reimbursement basis, (~~((such))~~) the loss ratios (~~((shall))~~) must be on the basis of incurred health care expenses and earned premiums for (~~((such))~~) the period.

(2) All filings of rates and rating schedules (~~((shall))~~) must demonstrate that actual and expected losses in relation to premiums comply with the requirements of this chapter and are not excessive, inadequate or unfairly discriminatory.

(3) Every insurer providing Medicare supplement policies in this state (~~((shall))~~) must annually file its rates, rating schedules, and supporting documentation including ratios of incurred losses to earned premiums demonstrating that it is in compliance with the applicable loss ratio standards and that the rating period for (~~((which))~~) the policy is (~~((rated is))~~) reasonable (~~((in accordance with))~~) according to accepted actuarial principles and experience. If the initial rating period for (~~((which))~~) the policy is (~~((initially rated is))~~) more than one year, ratios of incurred losses to earned premiums (~~((shall))~~) must be filed by number of years of policy duration. Supporting documentation (~~((shall))~~) must include the amounts of unearned premium reserve, policy reserves, and claim reserves and liabilities, both nationally and for this state. This annual filing is in addition to filings made by insurers to establish initial rates or request rate adjustments required by WAC 284-66-240.

(4) Incurred losses (~~((shall))~~) must include claims paid and the change in claim reserves and liabilities. Incurred losses (~~((shall))~~) may not include policy reserves, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, profit, or claims processing costs. Where coverage is provided by a health care service contractor or health maintenance organization, health care expense costs may not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, and claims processing costs.

(5) The following criteria will be used to determine whether policy forms are in compliance with the loss ratio standards of this section:

(a) For the most recent year, the ratio of the incurred losses to earned premiums is greater than or equal to the applicable percentages contained in this section; and

(b) The expected losses in relation to premiums over the entire rating period (~~((for which the policy is rated))~~) complies with the requirements of this section, relying on the judgment of the pricing actuary and acceptable to the commissioner; and

(c) (~~((For issue age level premium rated policies, an expected loss ratio for the third policy year, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force fewer than three years. For community rated policies the applicable percentage shall be demonstrated for the three most recent accounting periods. The applicable percentage shall be as defined in subsection (6) or (7) of this section.~~

~~((d))~~) For purposes of rate making and rate adjustments, similar policy forms (~~((shall))~~) must be grouped together according to the rules set forth in WAC 284-60-040. All Medicare supplement policies of an issuer issued for delivery between January 1, 1989, and July 1, 1992, are considered "similar policy forms" except those forms specifically approved under the standards of WAC 284-66-063 and 284-66-203.

~~((e))~~) (d) The commissioner may consider additional criteria including, but not limited to:

(i) Equitable treatment of policyholders; and

(ii) The amount of policy reserves as defined for the insurer's statutory annual statement.

(6) Medicare supplement insurance policies issued by authorized disability insurers and fraternal benefit societies (~~((shall be))~~) are expected to return to a policyholder in the form of aggregated loss ratios under the policy, at least sixty-five percent of the earned premiums in the case of individual policies, and seventy-five percent in the case of group policies.

(7) The minimum anticipated loss ratio requirement(~~(s)~~) for health maintenance organizations and health care service contractors (~~(shall be)~~) is seventy percent for individual forms and eighty percent for group contract forms. The minimum anticipated loss ratios are deemed to be met if the health care expense costs of the health maintenance organization or health care service contractor are seventy percent or more of the earned premium charged individual subscribers, or eighty percent or more of the earned premium charged subscribers covered under a group contract.

AMENDATORY SECTION (Amending Matter No. R 96-2, filed 4/11/96, effective 5/12/96)

WAC 284-66-203 Loss ratio and rating standards and refund or credit of premium. (1) Loss ratio and rating standards. For policies issued on or after July 1, 1992, and those policies specifically approved by the commissioner under WAC 284-66-063 (~~(prior to)~~) before July 1, 1992:

(a) A Medicare supplement policy form or certificate form must be rated on an issue-age level premium basis or community rated basis, as described (~~(at)~~) in WAC 284-66-243(~~(6)~~), ~~in order to meet the standards of WAC 284-66-310)~~ (7).

(b) A Medicare supplement policy form or certificate form (~~(shall)~~) may not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization or health care service contractor on a service rather than reimbursement basis and earned premiums for (~~(such)~~) the period (~~(and in accordance with)~~), according to accepted actuarial principles and practices.

(c) All filing of rates and rating schedules (~~(shall)~~) must demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions (~~(shall)~~) must

also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(d) For purposes of applying subsection (1)(b) of this section and WAC 284-66-243 (3)(c) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

(e) For policies issued (~~((prior to))~~) before April 28, 1996, expected claims in relation to premiums (~~((shall))~~) must meet:

(i) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(ii) The appropriate loss ratio requirement from WAC 284-66-203 (1)(b)(i) and (ii) when combined with actual experience beginning with April 28, 1996, to date; and

(iii) The appropriate loss ratio requirement from WAC 284-66-203 (1)(b)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

(iv) In meeting the tests in (e)(i), (ii), and (iii) of this subsection, and for purposes of attaining credibility, with the prior written approval of the commissioner, an issuer may combine experience under policy forms (~~((which))~~) that provide substantially similar coverage. Once a combined form is adopted, the issuer may not separate the experience, except with the prior written approval of the commissioner.

(2) Refund or credit calculation.

(a) An issuer (~~((shall))~~) must collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in WAC 284-66-232 for each type in a standard Medicare supplement benefit plan.

(b) If on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3) in year three or later, then a refund or credit calculation is required. The refund calculation (~~((shall))~~) must be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year (~~((shall))~~) must be excluded. This subsection applies only to annual experience reporting. Any revision of premium rates must be filed with and approved by the commissioner (~~((in accordance with))~~) according to WAC 284-66-243.

(c) For policies or certificates issued (~~((prior to))~~) before July 1, 1992, the issuer (~~((shall))~~) must make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the effective date of

this section. The first ~~((such))~~ report ~~((shall be))~~ is due by May 31, 1998.

(d) A refund or credit ~~((shall))~~ may be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. ~~((Such))~~ The refund ~~((shall))~~ must include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event ~~((shall))~~ may it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due ~~((shall))~~ must be made by September 30 following the experience year ~~((upon which))~~ that is the basis for the refund or credit ~~((is based))~~.

(3) Annual filing of premium rates.

On or before May 31 of each calendar year, an issuer of standardized Medicare supplement policies and certificates issued ~~((in accordance with))~~ according to WAC 284-66-063, ~~((shall))~~ must file its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner on the form provided at subsection (6) of this section. The supporting documentation ~~((shall))~~ must also demonstrate ~~((in accordance with))~~, according to actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. ~~((Such))~~ The demonstration ~~((shall))~~ must exclude active life reserves. An expected third-year loss ratio ~~((which))~~ that is greater than or equal to the applicable percentage ~~((shall))~~ must be demonstrated for policies or certificates in force less than three years.

(4) As soon as practicable, but ~~((prior to))~~ before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state ~~((shall))~~ must file with the commissioner, ~~((in accordance with))~~ according to the applicable filing procedures of this state:

(a)(i) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. ~~((Such))~~ The supporting documents as necessary to justify the adjustment ~~((shall))~~ must accompany the filing.

(ii) An issuer ~~((shall))~~ must make ~~((such))~~ any premium adjustments as are necessary to produce an expected loss ratio under ~~((such))~~ the policy or certificate ~~((as will conform))~~ to comply with minimum loss ratio standards for Medicare supplement policies and ~~((which))~~ that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for ~~((such))~~ the Medicare supplement policies or certificates. No

premium adjustment (~~((which))~~) that would modify the loss ratio experience under the policy other than the adjustments described (~~((herein shall))~~) in this section may be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(iii) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

(b) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. (~~((Such))~~) The riders, endorsements, or policy forms (~~((shall))~~) must provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(5) Public hearings.

(a) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for policy form or certificate form if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for (~~((such))~~) the reporting period. Public notice of (~~((such))~~) the hearing (~~((shall))~~) must be furnished in a manner deemed appropriate by the commissioner.

(b) This section does not in any way restrict a commissioner's statutory authority to approve or disapprove rates.

(6) Annual Medicare supplement insurance reporting form:

<p>Annual Filing of Premium Rates and Experience <u>To be filed on or before May 31 of each calendar year</u></p>
<p>Experience from January 1 to December 31, of _____(year) _____ reported by duration for all business from inception to December 31, (((49))) 20_____.</p>
<p>Compan y Name _____</p>
<p>Address _____</p>

NAIC Group Code	NAIC Company Code	CIC Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Plan	Type _____	Form No. _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Premium Rates [Attach schedule]

Insurance is [check one]	Group _____ _____ _____	or, Individual _____ _____ _____
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Washington Experience. [Show all experience for the reported calendar year (separately for each duration).]

<u>Policy</u> <u>Duration</u>	<u>Incurred</u> <u>Losses</u>	<u>Earned</u> <u>Premiums</u>	<u>Loss</u> <u>Ratio</u>	<u>Claim</u> <u>Reserves</u>

I hereby certify that I have supervised the preparation of this experience exhibit, that all durational information has been furnished, and to the best of my knowledge, the data is accurate and is in compliance with RCW 48.66.150 and WAC 284-66-203.

Signature of
Officer

Date

Name and Title
of Officer

Prepared by

Phone Number

Phone Number

|
|
|

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92,
effective 3/27/92)

WAC 284-66-210 Policy reserves required. This section (~~shall apply~~) applies to every group and individual policy of an issuer (~~which~~) that relates its benefits to Medicare. The term "policy reserve" is intended to apply to all types and forms of insurance equally, whether they are called policies, contracts, or certificates. For all forms (~~which~~) that are issued on a level premium basis, policy reserves will be required. The policy reserve is in addition to claim reserves and premium reserves. The definition of the date of incurrual must be the same for both claim reserves and policy reserves. Policy reserves (~~shall~~) must be based upon the following minimum standards:

(1) Morbidity should be based upon a reasonable expectation of future claim costs for the benefits being provided. At time of policy issue this would be the morbidity assumptions used to price the contract. For later durations the morbidity should reflect the experience (~~which~~) that emerges including the effects of inflation and utilization. All morbidity assumptions must be reasonable in the view of the commissioner.

(2) The interest rate used may not exceed the maximum rate permitted by statute in the valuation of life insurance issued on the same date as the Medicare supplement policy.

(3) Termination rates (~~shall~~) must be on the same basis as the mortality table permitted by statute in the valuation of life insurance issued on the same date as the Medicare supplement policy or on another basis satisfactory to the commissioner.

(4) The minimum reserve is that calculated on the one-year full preliminary term method. This method produces a terminal reserve of zero at the first policy anniversary. The preliminary term method may be applied only in relation to the date of issue of a policy. Reserve adjustments introduced later as a result of rate increases, revisions in assumptions, or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis. (~~Such~~) The adjustments (~~shall~~) must be determined as follows:

(a) Present value of future payments of claim costs for benefits, determined using revised assumptions based on anticipated experience;

(b) Less the present value of future net premiums, determined using revised assumptions based on anticipated experience;

(c) Less the liability for contract reserves at the valuation date.

(5) Negative reserves on any benefit may be offset against positive reserves for other benefits in the same policy or contract, but the total policy reserve with respect to all benefits combined may not be less than zero.

(6) The minimum policy reserve (~~shall~~) must include a reasonable margin for the risk of adverse selection.

AMENDATORY SECTION (Amending Order R 92-7, filed 8/19/92, effective 9/19/92)

WAC 284-66-220 Medicare supplement refund calculation form required. The form provided in WAC 284-66-232 (~~shall~~) must be filed with the commissioner annually (~~not later than~~) by May 31st of each calendar year beginning May 31, 1993. The form is to be filed in addition to the NAIC experience exhibit and not in lieu thereof.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-240 Filing requirements and premium adjustments. (1) (~~Unless such forms meet the standards of WAC 284-66-063 and 284-66-203,~~) All policy forms issued or delivered on or after January 1, 1990, and before July 1, 1992, as well as any future rate adjustments (~~thereto, shall~~) to such forms, must demonstrate compliance with the loss ratio requirements of WAC 284-66-200 and policy reserve requirements of WAC 284-66-210, unless the forms meet the standards of WAC 284-66-063 and 284-66-203. All filings of rate adjustments (~~shall~~) must be accompanied by the proposed rate schedule and an actuarial memorandum completed and signed by a qualified actuary as defined in WAC 284-05-060. In addition to the actuarial memorandum, the following supporting documentation must be submitted to demonstrate to the satisfaction of the commissioner that rates are not excessive, inadequate, or unfairly discriminatory and otherwise comply with the requirements of this chapter. If any of the items listed below are inappropriate due to the pricing methodology (~~utilized~~) used by the pricing actuary, the commissioner may waive the requirements upon request of the issuer.

(a) Filings of issue age level premium rates (~~shall~~) must be accompanied by the following:

(i) Anticipated loss ratios stated on a policy year basis for the period for which the policy is rated. Filings of future rate adjustments must contain the actual policy year loss ratios experienced since inception;

(ii) Anticipated total termination rates on a policy year basis for the period for which the policy is rated. The termination rates should be stated as a percentage and the source of the mortality assumption must be specified. Filings of future rate adjustments must include the actual total termination rates stated on a policy year basis since inception;

(iii) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(iv) Schedule of total compensation payable to agents and other producers as a percentage of premium, if any;

(v) Specimen copy of the compensation agreements or contracts between the issuer and its agents, brokers, general agents, or others whose compensation is based in whole or in part on the sale of Medicare supplement insurance policies,

~~((such))~~ the agreements demonstrating compliance with WAC 284-66-350 (where appropriate);

(vi) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

(b) Filings of community rated forms (~~((shall))~~) must be accompanied by the following:

(i) Anticipated loss ratio for the accounting period for which the policy is rated. The duration of the accounting period must be stated in the filing, established based on the judgment of the pricing actuary, and must be reasonable in the opinion of the commissioner. Filings for rate adjustment must demonstrate that the actual loss ratios experienced during the three most recent accounting periods, on an aggregated basis, have been equal to or greater than the loss ratios required by WAC 284-66-200.

(ii) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(iii) Schedule of total compensation payable to agents and other producers as a percentage of premium, if any;

(iv) Specimen copy of the compensation agreements or contracts between the insurer and its agents, brokers, general agents, or others whose compensation is based in whole or in part on the sale of Medicare supplement insurance policies, ~~((such))~~ the agreements demonstrating compliance with WAC 284-66-350 (where appropriate);

(v) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

(2) Every issuer (~~((shall))~~) must make (~~((such))~~) premium adjustments (~~((as))~~) that are necessary to produce an expected loss ratio under (~~((such))~~) the policy (~~((as))~~) that will conform with the minimum loss ratio standards of WAC 284-66-200.

(3) No premium adjustment (~~((which))~~) that would modify the loss ratio experience under the policy, other than the adjustments described in this section, may be made with respect to a policy at any time other than upon its renewal or anniversary date.

(4) Premium refunds or premium credits (~~((shall))~~) must be made to the premium payer no later than upon renewal if a credit is given, or within sixty days of the renewal or anniversary date if a refund is provided.

(5) For purposes of rate making and requests for rate increases, all individual Medicare supplement policy forms of an issuer are considered "similar policy forms" including forms no longer being marketed.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-243 Filing and approval of policies and certificates and premium rates. (1) An issuer (~~((shall))~~) may not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner (~~((in accordance with))~~) according to the filing requirements and procedures prescribed by the commissioner.

(2) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state that the policy or certificate was issued.

(3) An issuer (~~((shall))~~) may not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner (~~((in accordance with))~~) according to the filing requirements and procedures prescribed by the commissioner.

~~((+3))~~ (4) (a) Except as provided in (b) of this subsection, an issuer (~~((shall))~~) may not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(b) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

- (i) The inclusion of new or innovative benefits;
- (ii) The addition of either direct response or agent marketing methods;
- (iii) The addition of either guaranteed issue or underwritten coverage;

(iv) The offering of coverage to individuals eligible for Medicare by reason of disability. The form number for products offered to enrollees who are eligible by reason of disability must be distinct from the form number used for a corresponding standardized plan offered to an enrollee eligible for Medicare by reason of age.

(c) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare SELECT policy, or a group Medicare SELECT policy.

~~((4))~~ (5) (a) Except as provided in (a)(i) of this subsection, an issuer ~~((shall))~~ must continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form ~~((shall))~~ is not ~~((be))~~ considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(i) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty days ~~((prior to))~~ before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer ~~((shall))~~ may no longer offer for sale the policy form or certificate form in this state.

(ii) An issuer that discontinues the availability of a policy form or certificate form ~~((pursuant to))~~ under (a)(i) of this subsection, ~~((shall))~~ may not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(b) The sale or other transfer of Medicare supplement business to another issuer ~~((shall be))~~ is considered a discontinuance for the purposes of this subsection.

(c) A change in the rating structure or methodology ~~((shall be))~~ is considered a discontinuance under (a) of this subsection, unless the issuer complies with the following requirements:

(i) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in ~~((which))~~ that the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(ii) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential ~~((which))~~ that is in the public interest.

~~((5))~~ (6) (a) Except as provided in (b) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan ~~((shall))~~ must be combined for purposes of the refund or credit calculation prescribed in WAC 284-66-203.

(b) Forms assumed under an assumption reinsurance agreement (~~((shall))~~) may not be combined with the experience of other forms for purposes of the refund or credit calculation.

~~((+6+))~~ (7) An issuer may set rates only on a community rated basis or on an issue-age level premium basis for policies issued prior to January 1, 1996, and may set rates only on a community rated basis for policies issued after December 31, 1995.

(a) For policies issued prior to January 1, 1996, community rated premiums (~~((shall))~~) must be equal for all individual policyholders or certificateholders under a standardized Medicare supplement benefit form. Such premiums may not vary by age or sex. For policies issued after December 31, 1995, community rated premiums must be set according to RCW 48.66.045(3).

(b) Issue-age level premiums must be calculated for the lifetime of the insured. This will result in a level premium if the effects of inflation are ignored.

~~((+7+))~~ (8) All filings of policy or certificate forms (~~((shall))~~) must be accompanied by the proposed application form, outline of coverage form, proposed rate schedule, and an actuarial memorandum completed, signed and dated by a qualified actuary as defined in WAC 284-05-060. In addition to the actuarial memorandum, the following supporting documentation must be submitted to demonstrate to the satisfaction of the commissioner that rates are not excessive, inadequate, or unfairly discriminatory and otherwise comply with the requirements of this chapter:

(a) Anticipated loss ratios stated on a calendar year basis by duration for the period for which the policy is rated. Filings of future rate adjustments must contain the actual calendar year loss ratios experienced since inception, both before and after the refund required, if any and the actual loss ratios in comparison to the expected loss ratios stated in the initial rate filing on a calendar year basis by duration if applicable;

(b) Anticipated total termination rates on a calendar year basis by duration for the period for which the policy is rated. The termination rates should be stated as a percentage and the source of the mortality assumption must be specified. Filings of future rate adjustments must include the actual total termination rates stated on a calendar year basis since inception;

(c) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(d) Schedule of total compensation payable to agents and other producers as a percentage of premium, if any;

(e) A complete specimen copy of the compensation agreements or contracts between the issuer and its agents, brokers, general

agents, as well as the contracts between general agents and agents or others whose compensation is based in whole or in part on the sale of Medicare supplement insurance policies. ~~((Such))~~ The agreements ~~((shall))~~ must demonstrate compliance with WAC 284-66-350 (where appropriate);

(f) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

NEW SECTION

WAC 284-66-247 Interim rate and form filing requirements for standardized plans H, I and J and prestandardized plans that include outpatient prescription drug benefits. The requirements of this section are in addition to all Medicare Supplement rate and form filing requirements set forth in this chapter.

(1) Form filings.

(a) To comply with the requirements of WAC 284-66-243(2), issuers are encouraged to use a generic rider or amendment that is bracketed for the purpose of identifying the modified policy forms. Riders or amendments may be used only for policies or certificates issued prior to January 1, 2006, and must be accompanied by a complete listing of the form numbers for all affected policies or certificates.

(b) After December 31, 2005, plans H, I, and J may not be issued to new enrollees using a rider or amendment to delete the outpatient prescription drug benefit. After that date, issuers must:

(i) Offer only new plans that are otherwise identical to their currently approved plans H, I, and J, with the outpatient prescription drug benefit removed. The new plans must incorporate all endorsements that have been previously approved by the commissioner.

(ii) Identify the new plan using the same form number as the currently approved corresponding plan, adding a unique identifier to the form number that distinguishes it from the plan with outpatient drug benefits.

(iii) Certify that the new plan, including any previously approved endorsements, is identical to the currently approved plan in all respects except for the deletion of the prescription drug benefit. The certification must be signed by an officer of the company.

(2) Rate filings.

(a) An issuer must submit revised rates for all policies or certificates that are modified using a rider or amendment to remove outpatient prescription drug coverage. The rates must be

accompanied by an actuarial memorandum signed by a qualified actuary as defined in WAC 284-05-060 and include no less than the following information:

(i) The form number of the rider or amendment being used to modify the policy or certificate along with form number of the applicable policy or certificate.

(ii) If the modification applies to a prestandardized plan, a detailed description of the deleted prescription benefits.

(iii) A description and calculation of how the rate modification was determined including the general description and source of each assumption used.

(iv) A separate rate page listing the current rate charged for the underlying plan, the rate adjustment for the deleted outpatient drug benefit, and the final rate.

(b) An issuer must submit rates for standardized plans H, I, and J that will be issued after December 31, 2005. The rates must be consistent with the rates filed for the corresponding plans H, I and J that have been modified by rider or amendment to remove the outpatient prescription drug benefit and include all the current requirements for Medicare supplement rate filings noted in this chapter.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-250 Filing requirements for out-of-state group policies. Every issuer providing group Medicare supplement insurance benefits to a resident of this state (~~((shall))~~) must file with the commissioner, within thirty days of its use in this state, a copy of the master policy and any certificate used in this state, (~~((in accordance with))~~) according to the filing requirements and procedures ((applicable)) that apply to Medicare supplement policies issued in this state.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-260 Riders and endorsements. (1) Effective January 1, 1990, subject to RCW 48.66.050(2), and except for riders or endorsements issued (~~((in accordance with))~~) according to subsection (2) of this section, no rider, endorsement, waiver, or any other means of modifying contractual benefits may be used by an issuer to exclude, limit, or reduce the coverage or benefits of a Medicare supplement insurance policy or certificate issued to a resident of this state. Only riders or endorsements (~~((which))~~) that increase benefits or coverage may be used in this state.

(2) Effective January 1, 1990, except for riders or endorsements issued to bring a policy into compliance with changes to the minimum benefit standards or other contractual benefits required by this chapter or as (~~((hereafter))~~) amended:

(a) An amendment to a Medicare supplement insurance policy or certificate (~~((which))~~) that increases the premium must be requested or accepted by the policyholder in writing; and

(b) Where separate additional premium is charged for a rider, endorsement or other amendment to the contractual benefits of a Medicare supplement insurance policy or certificate, the premium charged (~~((shall))~~) must be set forth in the policy.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-270 Standards for claims payment: Compliance with Omnibus Budget Reconciliation Act of 1987. (1) An issuer (~~((shall))~~) must comply with Section 1882 (c)(3) of the Social Security Act (as enacted by Section 4081 (b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA'87), P.L. 100-203) by:

(a) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(c) Paying the participating physician or supplier directly;

(d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address (~~to which~~) that all claims may be sent by Medicare carriers.

(2) Compliance with the requirements set forth in subsection (1) of this section (~~shall~~) must be certified on the Medicare supplement insurance experience reporting form.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-300 Requirements for advertising. (1) At least thirty days (~~(prior to)~~) before use in this state, every issuer who provides Medicare supplement insurance coverage to a resident of this state (~~shall~~) must provide the commissioner with a copy of any Medicare supplement advertisement (as advertisement is defined in WAC 284-50-030) intended for use in this state whether through written, radio, or television medium. In the case of radio or television advertising, an audio cassette or VHS cassette (~~shall~~) must be supplied on request of the commissioner.

(2) Advertising (~~shall~~) must comply with the standards of the Washington disability advertising regulation (WAC 284-50-010 through 284-50-230), and (~~shall set forth~~) must identify the name in full of the issuer and the location of its home office or principal office in the United States (if an alien issuer).

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-310 Attained age rating prohibited. (~~(With respect to Medicare supplement insurance policies and certificates initially sold to residents of this state on or after January 1, 1989,))~~ The commissioner has found and (~~(hereby))~~ defines it to be an unfair act or practice and an unfair method of competition, and a prohibited practice, for any issuer, directly or indirectly, to use the increasing age of an insured, subscriber, or participant as the basis for increasing premiums or prepayment charges with respect to Medicare supplement insurance. Accordingly, the rating practice commonly referred to as "attained age rating" is prohibited.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-320 Reporting of multiple policies. (1) On or before March 1st of each year, an issuer (~~(shall))~~ must report to the commissioner the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate on a form approved by the commissioner, substantially in the form provided in WAC 284-66-323:

- (a) Policy and certificate number; and
- (b) Date of issuance.

(2) The items set forth above must be grouped by individual policyholder.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-330 Standards for marketing. (1) Every issuer marketing Medicare supplement insurance coverage in this state, directly or through its producers, (~~(shall))~~ must:

(a) Establish marketing procedures to assure that any comparison of policies or certificates by its agents or other producers will be fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) Display prominently by type, stamp or other appropriate means, on the first page of the policy or certificate the following:

"NOTICE TO BUYER: THIS (POLICY, CONTRACT OR CERTIFICATE) MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES."

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has disability insurance and the types and amounts of any such insurance.

(e) Establish auditable procedures for verifying compliance with this section.

(2) In addition to the acts and practices prohibited in chapter 48.30 RCW, chapters 284-30 and 284-50 WAC, and this chapter, the commissioner has found and hereby defines the following to be unfair acts or practices and unfair methods of competition, and prohibited practices for any issuer, or their respective agents either directly or indirectly:

(a) Twisting. Making misrepresentations or misleading comparisons of any insurance policies or issuers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, (~~(retain)~~) keep, or convert any insurance policy.

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or otherwise applying undue pressure to coerce the purchase of, or recommend the purchase of, insurance.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing (~~(which)~~) that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-340 Appropriateness of recommended purchase and excessive insurance. (1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent ~~((shall))~~ must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of a Medicare supplement ~~((coverage which))~~ policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

(3) An issuer may not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-350 Permitted compensation arrangements.

(1)(a) The commissioner has found and hereby defines it to be an unfair act or practice and an unfair method of competition, and a prohibited practice, for any issuer, directly or indirectly, to provide commission to an agent or other representative for the solicitation, sale, servicing, or renewal of a Medicare supplement policy or certificate ~~((which))~~ that is delivered or issued for delivery to a resident within this state unless the commission is identical as to percentage of premium for every policy year as long as the coverage under the policy or certificate remains in force with premiums being paid, or waived by the issuer, for ~~((such))~~ the coverage.

(b) Each commission payment must be made by the issuer no later than sixty days following the date on which the applicable premiums, ~~((upon which the commission is calculated))~~ that are the basis of the commission calculation, were paid. Each ~~((such))~~ payment must be paid to either the producing agent who originally sold the policy or to a successor agent designated by the issuer to replace the producing agent, or shared between them on some basis. The distribution of the commission payments ~~((shall))~~ must be designated by the issuer in its various agents' commission agreements and it may not terminate, reduce

or (~~retain~~) keep the commission payment as long as the policy or certificate remains in force with premiums being paid, or waived by the issuer, for the coverage thereunder.

(c) Where an issuer provides a portion of the total commission for the solicitation, sale, servicing, or renewal of a Medicare supplement policy or certificate to a general agent, sales manager, district representative or other supervisor who has marketing responsibilities (other than a producing or successor agent), while such portion of total commissions continues to be paid it (~~shall~~) must be identical as to percentage of premium for every policy year as long as coverage under the policy or certificate remains in force with premiums being paid, or waived by the issuer, for (~~such~~) the coverage.

(2) For purposes of this section, "commission" includes pecuniary or nonpecuniary remuneration of any kind relating to the solicitation, sale, servicing, or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, advances on commissions, awards and finders fees.

(3) This section (~~shall~~) does not apply to salaried employees of an issuer who have marketing responsibilities if the salaried employee is not compensated, directly or indirectly, on any basis dependent upon the sale of insurance being made, including but not limited to considerations of the number of applications submitted, the amount or types of insurance, or premium volume.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

WAC 284-66-400 Chapter not exclusive. Nothing contained in this chapter (~~shall~~) may be construed to limit the authority of the commissioner to regulate Medicare supplement insurance policies or certificates under other sections of Title 48 RCW.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 284-66-077

Open enrollment.